DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Region IX

75 Hawthorne St.
Suite 401
San Francisco, CA 94105

Refer to: MCD-WCG-RRP

Gail L. Margolis, Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear Ms. Margolis:

The Centers for Medicare & Medicaid Services has completed its review of California's request to continue operation of the Specialty Mental Health Services Consolidation waiver under section 1915(b) of the Social Security Act (the Act). After analysis of the State's request and supplemental materials, we believe that additional information is required. All waiver requests under section 1915(b) of the Act require the State to document the cost-effectiveness of the project, its effect on accessibility and quality of services, and its projected impact on the Medicaid program (42 CFR 431(b)(2)).

Pursuant to the provisions of section 1915(f)(2) of the Act, our additional information request stops the 90-day clock for making a final decision on whether or not to approve the State's waiver renewal request. A second 90-day clock will start upon receipt of the State's response to this request for additional information. We request that the State respond within 45 days in order to facilitate CMS' review of its response within the current temporary extension period. We appreciate your assistance. If you have any questions, please contact Rebecca Paul at (415) 744-3553.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid

Attachment

cc: Theresa A. Pratt, Director, Division of Integrated Health Systems, CMSO

Specialty Mental Health Services Consolidation waiver
August 2002 Waiver Renewal
CMS Additional Information Request

General Questions

1. How does the California Specialty Mental Health Services Consolidation waiver program comply with the Dear State Medicaid Director letter dated July 17, 2001 pertaining to consultation with Native Americans in relation to the waiver renewal?

2. Please submit a chart similar in concept to that submitted with the 1997 renewal that addresses if/how coverage arrangements differ in each county. For each county, please specify each entity that provides specialty mental health services in that county and which services they cover. For programs, please specify how many enrollees are affected by the different programs/arrangements.

Access

3. Section II, M, page 17 – The 2002 waiver renewal request reiterates statements made in the 1999 request pertaining to access to care, including the following: "requests for services to treat urgent psychiatric conditions are acted upon within one hour of the request," and "Medi-Cal beneficiaries are able to rely on MHP provider networks for timely service referrals." We are particularly interested in these access issues in light of findings from various studies of mental health services, including the report on *Psychiatric Hospital Beds in California* (August 2001) and the 2002 Independent Assessment. The report on *Psychiatric Hospital Beds* found difficulty in accessing hospital beds, particularly for children, and the shortage experienced by 81% of participating hospitals in child and adolescent beds (p. 14). The Independent Assessment found a shortage of psychiatric services for children that "leads to appointment delays and waiting times" (page 26), a statement with which the State specifically concurred. The Independent Assessment further documented a lack of "step-down facilities" (page 27).

   Please provide more details about findings pertaining to access to services for Medi-Cal enrollees, including information from DMH's monitoring of MHPs. Given documented provider shortages (psychiatric services, "step-down facilities"), how is the State ensuring adequate access to services for waiver enrollees?

4. Children with Special Health Care Needs criteria
   a) Has the Children with Special Health Care Needs (CSHCN) Task Force identified any issues specific to the services CSHCN receive under the waiver?
   b) The data and information that the State submitted to meet the terms and conditions of the waiver pertaining to CSHCN is a rich source of information about specialty mental health services provided to children. Given the feedback that CMS provided regarding the data submitted, has the State considered using the data to develop specific tracking/monitoring reports? How will the data be analyzed/used in the future?

5. Section IV, A, 6, page 38 -- The waiver states that CMHDA, serving as an ASO, authorizes and pays for basic outpatient specialty mental health services needed by foster children who are placed out-of-county. How are inpatient services handled for out-of-county foster children?

Informing

6. Section II, A, 5, page 22 -- The waiver renewal states that the State "provides ongoing information on the program to new applicants through county welfare departments." Please define "ongoing," and describe the information that is provided on an ongoing basis. The renewal also states that the "State will issue annual notices regarding the information available from the MHPs to all Medi-Cal households, so all beneficiaries will receive information about the program on a regular basis." What information is the State currently providing on an annual basis?

7. Section II, A, 6, page 24 -- The State notes that beneficiary brochures and other program information are translated by each MHP into each threshold language for that county. How do MHPs address the needs of non-English speaking beneficiaries whose language group do not meet the criteria of a "threshold language?"

Monitoring

8. Section II, M, page 17 -- The waiver renewal states that the State reviews of MHPs consisted of "chart reviews of SD/MC inpatient hospitals and outpatient programs." Who reviews FFS/MC inpatient hospitals? Does this statement refer to all outpatient programs, or only those outpatient programs traditionally claimed through SD/MC? If the latter, who reviews those outpatient programs traditionally claimed through FFS/MC?

9. Independent Assessment, pages 25, 37, 38, 47 -- The Independent Assessment documents a number of disparities in requirements on, and oversight of, FFS/MC providers. Does State monitoring efforts look separately at SD/MC and FFS/MC providers? If so, what findings have been identified? If not, how does the State plan to address these monitoring disparities? For example, while the State holds that they prefer to rely on goals for timeliness of service rather than "require higher levels of capacity monitoring by network fee-for-service providers," has the State found any disparities in timeliness between SD/MC and FFS/MC providers?

Financial questions

10. Section II, I, page 16 -- Enrollment projections: Given that the number of enrollees for the last 3 years (FY99/00 to 01/02) has increased on an average of 6% per year, why does the State project enrollment increases of only 3% per year?

11. Realignment funds:
    a) Section II, N, pages18-21 -- Has the State taken into account any reductions in realignment revenues due to reductions in sales taxes due to the economy?
    b) Section II, N, page 20 -- In a number of instances, the waiver refers to realignment dollars -- including Table S1 in Appendix II-N, Table S2 (p. 20), and in the second paragraph on p.

21. Are these realignment dollars the subset of all realignment funds deposited into counties' mental health accounts, or all realignment dollars that counties receive?

12. Section II, N, page 19 -- We would like more detail regarding the formula for calculating increases in SGFs transferred to counties with above average need. Please address the following:
    a) Please further describe how county MHPs' weighted relative need is estimated. How did the State develop the statewide weighted-average cost per Medi-Cal beneficiary in FY 1993-94?
    b) Why hasn't weighted relative need been recalculated since the waiver program began? How can the State assure that those MHPs that have not received a growth increase since FY 1995-96 are still above the weighted average cost per Medi-Cal beneficiary?
    c) If the relative need increase has been frozen or has not occurred since the beginning of the program, please clarify that any further cost increases due to changes in enrollment, utilization, or cost of living come from a county's realignment (or other) funds.

13. Section II, N, page 20, Table S2 -- It is our understanding that the State's intent in showing a "surplus" in Table S2 is to illustrate that counties have ample funds to use for Title XIX match. However, it is also our understanding that county realignment funds are also intended to be used to provide services to non-Medicaid populations and that, therefore, there are other uses for these funds. Given these competing demands, how does the State ensure that adequate funds will be available for title XIX match? Overall, is there a monitoring process that assures that mental health realignment allocations are used for mental health services? Is the "surplus" referred to in Table S2 used solely for non-Medi-Cal mental health services?

14. MAA Expenses
    a) Table 2: Medi-Cal Specialty Mental Health Services Annual Costs Under the Waiver -- According to CMS' FY2001 financial management review of the MAA program, the portion of the total computable MAA expenditures claimed through DMH was approximately $11 million. According to Table 2, actual MAA expenses were approximately $26 million in SFY2000-01. Please explain the differences.
    b) Section V, B, 1, page 58 -- Please explain why the State attributed the significant increase (58% increased PMPM) in the MAA expenses during SFY 99/00 to the waiver. Why does the State expect that MAA expenses will increase more under the waiver than without the waiver?

15. Tables 1 and 2: Medi-Cal Specialty Mental Health Services Annual Costs Under the Waiver -- Please provide more detail regarding your assumptions about growth in inpatient hospital spending without the waiver. In your documentation, you note that the number of hospitals providing inpatient psychiatric care fell both for Medi-Cal beneficiaries and for all patient populations in California and nationally. How do you reconcile this fact with your assumption that costs for inpatient care would have continued to grow rapidly without the waiver? How did MHPs control spending on inpatient hospital services so effectively under the waiver?

16. Sole source (Exhibit 2)
    a. In order to help place Medi-Cal into the broader market for mental health services in California, please explain the degree to which Medi-Cal providers overlap with providers that serve the broader population, and the extent to which the services that private companies offer differ from Medi-Cal services. Also, please provide information regarding private companies that either offer mental health insurance products in California or provide administrative services for large businesses that self-insure for health care costs.
    b. Has the State has brought up this issue with the program's stakeholders since the last renewal? Is sole source explicitly supported by stakeholders?

Independent Assessment

17. Independent Assessment, page 31 -- Please clarify if MHPs that provide services above the Medi-Cal benefit package are not claiming FFP for the provision of these services.

18. Independent Assessment, page 10 -- The Independent Assessment notes that the move to capitation is "under development." Is the State still considering moving the waiver to capitation in the future? What is the current time table for such a change?